### LOW-INCOME ASSISTANCE/ MEDICAID

# SECTION

### Introduction to Medicaid

Established in 1965, Medicaid is a state and federally funded health care program designed to assist low income individuals and families. In order to qualify for Medicaid assistance the individual/family must meet certain eligibility requirements. The Medicaid program is administered on the state level; as a result, some requirements and rules vary from state to state.

In Indiana, Medicaid is administered through the Family and Social Services Administration (FSSA) by the Department of Family Resources (DFR). Changes to the Medicaid program come from the Indiana General Assembly as well as the Center for Medicare and Medicaid Services (CMS).

### **Medicaid Covered Services**

Medicaid can help pay for the following types of medical services:

- · Physician services;
- Hospital Inpatient and Outpatient care and Rural Clinic services;
- Other clinic, laboratory, and x-ray services;
- Nursing facility services Skilled and intermediate care, and intermediate care for the mentally retarded;
- Dental:
- Optometric services including eyeglasses and prosthetics devices;
- · Podiatry services;
- · Chiropractic services;
- Hospice services;
- Home health care services;
- Care coordination services for pregnant women, persons with HIV/AIDS, and persons who are seriously mentally ill/ emotionally disturbed;
- Any other medical or remedial care recognized under Indiana law and specified by federal regulations;
- Prescription drugs;
- · Medical supplies and equipment;

### Medicaid Services (cont'd)

- Skilled Nursing Home (NH) care;
- Transportation to Medicaid-covered services;
- Nurse midwife services;
- Family planning;
- Health screening follow-up services for children;
- Physical, occupational, speech, and respiratory therapy; and
- Preventive care including screening, diagnosis, or necessary treatment for all medical recipients under age twenty-one.

### **Qualifying for Medicaid**

In Indiana the Department of Family Resources (DFR) determines eligibility and need for Medicaid services. Eligibility for singles, couples, and households is determined by a combination of factors that includes: medical needs, income levels, and assets (refer to page O-3 for income and asset figures). To apply for Medicaid, you must contact your local Department of Family Resources. The DFR must rule on your application within 45 days (or 90 days if you are applying because of a disability).

### **Indiana Medicaid Non-financial Eligibility Requirements**

- You must be a resident of the State of Indiana.
- You must be a US citizen or a non-citizen of eligible immigration status.
- Lawful immigrants, who enter the United States after August 22, 1996, are not eligible for full Medicaid coverage **for 5 years**.
  - During this time period legal immigrants can receive emergency medical care, if they meet the other Medicaid requirements.
  - Immigrants with no proof of legal residence can receive emergency medical care if they meet the other Medicaid requirements.
- You must also demonstrate a medical need in order to be eligible for Medicaid.

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In addition to the residency and medical need requirements, you **must** also meet one of the following categories:

- Individuals who are age 65 or older;
- Blind;
- Disabled:

**Note:** Even though you are receiving SSI disability benefits, you still must meet the income requirements of the Department of Family Resources to receive Medicaid.

- Refugees;
- Low-income families with dependent children. Recipients of Temporary Assistance for Needy Families (TANF) may be eligible in this category;
- Children under age 19 and individuals age 18,19, and 20 who have special living conditions such as being institutionalized, or living in a family with an income at or below the Federal Poverty Level (FPL).
- Pregnant women and newborns, up to 1 year old, if born to women who are receiving Medicaid.

### **Indiana Medicaid Financial Eligibility Requirements**

Financial eligibility is based on your (and your spouse's) income and assets. If the application is for a child the income and assets of his/her parents are included in determining eligibility.

### **MEDICAID** effective April 2010

	INCOME	ASSETS
SINGLE	\$674/month	\$1,500
COUPLE	\$1,011/month	\$2,250

- For a individuals with dependents, additional income of \$337 per dependent may be allowed.
- \$20 income disregard is not included.
- Income limits change annually based on the Social Security cost of living adjustment.

When applying for Medicaid, you should have ready your medical records, doctors statements of medical needs, statements of income, and information on your assets.

### Checklist of Documents You Will Need for Medicaid\*

- 1. Records showing your age and place of birth certificate, baptismal record, insurance policies
- 2. Your Social Security number, Medicare claim number, Railroad Retirement number, Veterans claim number
- 3. Record of marriage
- 4. Property deeds on property which you own but in which you do no live
- 5. Burial trust or pre-paid funeral arrangements
- 6. All life and medical insurance policies (for life insurance, you will need a written verification from the company of the current cash surrender value or the policy)
- 7. Documentation of all property transferred within the past five years
- 8. Records of your income and the income of spouse and dependent children in the home
  - A. SSI benefits: the check or letter or entitlement (if within 12 months). You can request verification from Social Security
  - B. Social Security benefits: the check or letter notification (if within 12 months). You can request verification from Social Security
  - C. Veterans benefits: the check or letter notification (if within 12 months).

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- D. Railroad Retirement benefits: the check or letter notification (if within 12 months).
- E. Unemployment compensation
- F. Retirement or Union benefits: the check or letter notification (if within 12 months).
- G. Income from rental property
- H. Earnings: name of employer, pay stubs, covering the last three months, verification of work expense
- 9. Bank statements showing the balance in any and all accounts owned (checking, savings, CD's, Christmas Club, etc.) for each month for which coverage is sought
- 10. Verification of ownership and current value of any stocks or bonds owned (includes U.S. Savings Bonds)
- Documents pertaining to any trust or which either applicant or spouse is the beneficiary or for which either is the trustee
- 12. Verification of the current market value of any non-motorized recreational vehicle, camper trailer, boat, etc. owned jointly or individually by applicant or spouse
- 13. A listing of the contents of any safety deposit box rented by either spouse (further documentation may be required depending on the contents)
- 14. A signed statement of the amount of cash both spouses currently hand on hand
- 15. Description and verification of the current value of any other available resource not listed

<sup>\*</sup>From list provided by the Senior Law Project.

### **Assets Typically Counted by Medicaid:**

- Cash
- Money in the bank; checking, savings, etc.
- Stocks
- Bonds
- Cash surrender values of insurance policies

Eligibility depends on how many resources you own on the first day of any calendar month. You are then either eligible or in-eligible for the rest of the month regardless of any resource changes during the month.

### **Exempted Assets**

When applying for Medicaid, some assets are not counted and are therefore classified as being "exempt". Exempt Assets may include:

- Your Home: Your home is exempt:
  - 1. When it is the principal residence for the applicant, or for their spouse or children (if these children are under age 21, or are disabled or blind).
  - 2. If a sibling with equity interest in the home resided in the home for at least one year prior to the patient's NH admission.
  - 3. If a child was living in the home for at least 2 years prior to the NH admission with the purpose of providing needed care to the parent.
- Life Insurance Cash Surrender Values are exempt if the death benefit (face value) of all policies, (excluding term life insurance) is \$10,000 or less, and the beneficiary is one's estate or the funeral home. The \$10,000 limit is reduced by any amount that is in an irrevocable funeral trust.
- Burial or funeral trusts are exempt if irrevocable, regardless of their value, as long as the trust money is tied to specific services.

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- **Income producing property** is exempt if the income produced is greater than the expenses of ownership. The income from these properties may be considered by Medicaid. Other real estate that is in the name of the community spouse is exempt.
- Household goods such as furniture, appliances, etc., and personal effects such as clothing are exempt.
- One vehicle, regardless of value, is exempt if it is necessary for employment, medical treatment, or if you are disabled, and the vehicle has been altered to accommodate your disability.

If you feel that you qualify under the assets limits but your monthly income is above the accepted Medicaid limits, you may be able to qualify using the "Spend-Down" provision.

### Spend-Down

Medicaid Spend-Down provision allows a person, whose income is above the standard, to receive assistance with medical bills from Medicaid. You will still need to meet the asset standard in order to qualify. In order to be eligible for Medicaid with a spend-down your monthly medical bills would need to be higher than your monthly income.

Amounts paid by insurance, such as Medicare or Part D drug plans, are not eligible to be counted toward the spend-down amount.

The Spend-Down amount is determined by subtracting the medical expenses from your monthly income; thereby possibly lowering your income to within the Medicaid guidelines. Example:

Your actual monthly total income = \$900

Maximum income to qualify for

Medicaid (single) =  $\frac{$674}{}$ Your spend-down amount is = \$226

In this example, if your total incurred medical expense this month is greater than \$226, you may qualify for Medicaid under the spend-down rule.

Beginning January 1, 2006, **Spend-Down works like an insurance deductible**. Medical providers file their claims for services with Medicaid and the Spend-Down amount is deducted. A claim to Medicaid is filed after Medicare or other insurance has processed the claim. Once the spend-down amount is satisfied in a month, Medicaid will pay for all other covered services. In a few situations you must provide bills or receipts to your local Department of Family Resources.

Medical expenses that cannot be filed directly with Medicaid are referred to as "non-claims". You must submit the documentation of these non-claims to the Medicaid office. Be sure to ask your caseworker how to submit non-claims.

### **Types of Non-Claims**

- Medical services paid for by a state or local program such as CHOICE or Township Trustee assistance.
- Medical services received from a provider who does not participate in the Medicaid program.
- Medical services received by non-member spouses and parents whose income was used to determine the Spend-Down.
- Bills for medical services received before the member became eligible for Medicaid.
- Co-payments required by other insurance coverage and Medicare.

### **Medicaid Spend-Down Summary Notice**

On the 2nd business day of the month, a notice will be sent to you. This notice will include the claims applied toward the spend-down, months for which the spend-down is applied, and providers who must be paid. Only claims used to meet the spend-down will be included on the summary notice. Providers cannot expect payment until after the Summary Notice has been sent to you. See example on pages O10 & O11.

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In determining Medicaid eligibility, **Supplemental Security Income (SSI)** does not count as income. **SSI** is Social Security income to people who are age 65 or older, or blind, or have a disability, and who have low incomes and little assets.

The spend-down process is on a month-to-month basis. You may qualify for one month, not the next, and then qualify again the next month.

### **Examples of allowable expenses to qualify for Medicaid:**

- Doctor visits
- Inpatient or outpatient medical care
- Prescription drugs
- Medical supplies & medical equipment
- Laboratory tests
- X-rays
- Health insurance premiums (including Medicare)
- Cost of transportation to medical appointments
- Hospice teams

## MEDICAID SPEND-DOWN SUMMRY NOTICE

Indianapolis, IN 46202

Medicaid ID Number: XXXXXXXXXXXX Case Worker ID; W12345

bills are not filed with Medicaid until after Medicare or other insurance had paid. This notice includes claims filed by your medical providers. It also includes non-claims, which are any medical expenses that you submitted to your local Office This is a summary of your medical bills that were processed from 05/01/06 through 05/31/06 for spend-down. Some of Family Resources.

### THIS IS NOT A BILL

Keep this notice and compare it to bills sent by your medical providers.

Your medical providers my bill you for the amounts shown in the column marked "Amount Applied to Spend-down". Medicaid will not pay the amounts in this column.

# Medical Expenses Processed for you May 2006 Spend-down

d d		
Possible Refund		
Future Credit		
See Notes Section	S	
Amount Applied to Spend-down	\$0.87	
Billed to Medicaid	\$0.00	
raid by Other Insurance	\$0.00	
Amount Charged	\$0.87	
Provider/ Service	BIOSCRIP PHARM COPAY	
Date Processed	05/23/06	
Date of Service	04/20/06	
	05/201	0

Indiana Family and Social Services Administration

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Date of	Date	Provider/	Amount	Paid by Other	Billed to	Amount Applied to	See Notes	Future	Possible
	Processed	Service	Charged	Insurance	Medicaid	Spend-down	Section	Credit	Refund
04/20/06	05/23/06	BIOSCRIP PHARM	\$3.00	80.00	\$0.00	\$3.00 C	)		
		COPAY							
04/20/06	05/23/06	BIOSCRIP PHARM	\$3.00	80.00	\$0.00	\$3.00	)		
		COPAY							
04/20/06	05/23/06	BIOSCRIP PHARM	\$3.00	\$0.00	\$0.00	\$3.00 C	C		
		COPAY							
04/26/06	05/23/06	DIALYSIS CLINIC	\$18,914.16	\$0.00	\$609.28	\$349.13	В		
		DIALYSIS							

Any amount of the provider's bill to Medicaid that is more than your append-down obligation Will be paid by Medicaid in accordance with reimbursement rules. Notes Section:
B: Any amou

This co-payment amount is itemized in the Summary Notice as a separate line item and is part of The total medical expense for the service you received.  $\ddot{c}$ 

# Summary of your spend-down status for the months listed in this notice as of 06/01/06.

Month/Year	Spend-down Amount	Status
May 2006	\$359.00	Spend-down satisfied

# Indiana Family and Social Services Administration

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### **Medicaid Nursing Home Assistance**

Prior to entering a nursing home, discuss whether the NH is a Certified facility, and if there is a waiting list for beds.

To qualify for Medicaid nursing home assistance (NH) costs, you must meet the asset criteria. If you qualify, your income except for a **personal needs allowance of \$52/month** will go towards paying for your care in the NH. Medicaid would then pay for any medical costs over and above your income.

See "**Spousal Impoverishment**" brochure for income and asset protections for the spouse at home.

Your medical criteria is assessed by case managers to determine if you are able to receive assistance, and what level of medical care you may require. The preadmission screening (**PAS**) results also determine whether you need to be in a nursing home, or with the proper assistance you can stay at home. If you refuse the PAS, you will not be eligible for Medicaid assistance for one full year from the date that you are admitted into a nursing home.

An **Elderlaw** attorney who is knowledgeable about Medicaid may be of help with planning, application, and appeals. These services may be obtained at a reduced cost through the **Legal Services Organization**, the **Senior Law Project**, **1-800-869-0212**, or through your local **Area Agency on Aging (AAA)**.

### **Spousal Impoverishment Provision**

The Spousal Impoverishment Amendments occurred in 1989. The purpose of these amendments is to **protect spouses of nursing home residents from losing all of their income and assets** to pay for the NH spouse's care. The law allows the spouse living in the community to keep some assets and income and still be able to get Medicaid assistance for the NH spouse. Income and assets are each treated a little differently under the Spousal Impoverishment Provision.

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### Income

The couple's income falls into two categories: Personal and Jointly Owned:

- 1. **Personal Income**: Income in one's own name remains that person's personal income. Ex: checks made out in the wife's name would be considered her income.
- 2. **Jointly Owned Income:** Jointly owned income from dividends, interest, or any jointly owned income is divided in half.

If you are the spouse at home, you may retain all of your personal income, plus half of the jointly owned income. As the spouse at home, (community spouse) when your income is less than \$1,823 per month, you may keep part of the income of your spouse who is in the nursing home, in order to bring your income up to that amount. This standard increases annually on July 1st.

The community spouse who needs more income to pay for mortgages, utilities, rent, etc. is able to appeal to Medicaid to keep more from what was to be paid to the nursing home. In order to appeal the shelter expenses must be greater than \$547 per month. The total income limit is then \$2,739 per month. Other dependent family members my also be able to keep some of the nursing home spouse's income.

### For special needs, the community spouse may appeal to keep more money.

### For Example:

Let's look at Charles and Hazel. Hazel lives at home; Charles is entering the nursing home. Their combined monthly income is \$2,325.

	Charles	Hazel	Joint
	(NH Spouse)	(At HomeSpouse)	
Soc Sec checks	\$900	\$600	\$0.00
Rental Property	\$0.00	\$0.00	\$450
Charles' IRA	\$375	\$0.00	\$0.00

Charles has \$1,500 in income (personal income plus 1/2 jointly owned income). Hazel has \$825 in income. Under the Spousal Impoverishment Provisions Hazel would be able to keep enough of Charles' income to bring her to the minimum standard of \$1,823. In this example Hazel would get to keep \$997 of Charles' income.

### **Assets**

In determining the assets of a couple for the Spousal Impoverishment Provision **a "Snapshot" Date must be determined**. The Snapshot Date is the first day of the first month a spouse is institutionalized for at least 30 days, or likely to be in a facility for at least 30 days. This date could be several years in the past. The snapshot is of the couple's assets on that date. The division of the assets is based on the what the couple owned on the Snapshot Date. Details of the assets would need to be recreated for a Snapshot Date in the past.

### For Example:

Let's go back to Charles and Hazel. Hazel lives at home; Charles entered the nursing home May 15, 2006. The Snapshot Date for Charles and Hazel is May 1, 2006. The division of Charles and Hazel's assets will be based on what they owned on May 1, 2006.

Most assets are considered joint assets between husband and wife (regardless of whose name they are in). The exception is real estate owned in one spouse's name. This real estate is considered personal property. The home and one car of any value are considered exempted assets, and are not counted in the division of assets. The Department of Family Resources sets a budget for the community spouse.

The community spouse is able to keep the highest of the following:

- Half of all countable assets, up to a maximum limit of \$109,560.
- A minimum of \$21,912.

The nursing home spouse is allowed to keep \$1,500 in assets. The at home spouse's

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assets must be transferred into their name within 90 days. So that only the allowed \$1,500 remains in the nursing home spouse's name.

**At Home Spousal Resource Limits** 

Total Couple's	At Home
Assets	Spouse's Share
\$219,120 or more	Maximum limit \$109,560
\$219,120 to \$43,824	½ Total Assets
\$21,912 to \$43,824	Minimum limit \$21,912
\$21,912 or less	All

Assets over the above amounts are applied towards the NH spouse's share of assets. The nursing home spouse's share must be spent towards their own care, until their total assets have reached **\$1,500**. Medicaid would then assist with paying for their care. The nursing home spouse's income will pay first, then Medicaid will help with the costs.

### For Example:

Charles and Hazel have \$75,000 in countable assets as of May 1, 2006. Hazel will be allowed to keep half of the assets, \$37,500. Charles will be allowed to keep \$1,500 of his share of the assets. They will have to "spend down" \$36,000 before Medicaid will begin paying. They can use the \$36,000 to pay for home improvements, purchasing new appliances or furniture, in addition to paying for Charles' nursing home care.

Hazel's Assets	Charles' Assets	Spend-down Assets
\$37,500	\$1,500	\$36,000

Once the initial Medicaid eligibility has been determined, the at home spouse's assets are not taken into consideration for Medicaid eligibility again. Only the nursing home spouse's assets will be reviewed. Protection under Spousal Impoverishment will not apply after the death of the NH spouse, or if the community spouse enters a nursing home.

### **Transferring of Assets**

When applying for Medicaid, Medicaid will look back over a period of time to see whether there has been any **transfer of assets** for less than the fair market value of those assets. If assets have been transferred (other to a spouse), there may be a period of ineligibility for Medicaid assistance.

Transfers made before February 8, 2006, are subject to a 36 month (or 3 year look back period). The exception to this is for trusts. Transfers into or out of trusts are subject to a 60 month or 5 years look back period. The number of months if ineligibility is calculated by dividing the uncompensated value of the asset transferred by \$3,898 (the average monthly cost of nursing home care). The period pf ineligibility begins with the month after the asset is transferred. A partial calendar month is "rounded down" to the lower month (7.45 months would be rounded down to 7 months). If all assets transferred are returned and then spent-down, there will be no penalty for Medicaid assistance.

All transfers made on or after February 8, 2006 are subject to a 5 year look back period. The ineligibility period will not begin until you are eligible for Medicaid and would be receiving nursing home level care. The months of ineligibility is calculates the same as the pre-2/6/06 transfers. There is no "rounding down." The Medicaid office is required to offer a hardship waiver process. Contact the Division of Family Resources for more information on the hardship waiver.

Transfers of property affect eligibility of only nursing home residents and persons who receive Home and Community-Based Services ("waivered services"). Other applicants or recipients are not affected by transfers.

### **Paying Back Medicaid**

Medicaid has a legal right to file claims to recover its costs from the estate of a deceased Medicaid beneficiary. This is called a **preferred claim**. The value of exempt resources may be recovered from your estate to cover the cost of any care/services that were provided and paid by Medicaid (**Preferred Lien**).

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### SUPPLEMENTAL SECURITY INCOME (SSI)

### SSI is a Federal Program that:

- Pays a monthly income to you if you are in financial need, aged 65+, blind, or disabled. You may receive both Social Security and SSI.
- Income, assets, and support from other sources will determine your SSI benefits.
- Exempted assets may differ from those used for Medicaid eligibility.

### **How is SSI different from Social Security?**

- Unlike Social Security, SSI is not based on your prior work experience, or the work experience of a family member.
- SSI is financed through the general funds of the US Treasury personal income taxes, corporate taxes, and other taxes. Social
  Security taxes (FICA Federal Insurance Contribution Act) do
  not fund SSI benefits.
- You must be blind, disabled, or at least 65 years old, and have limited income and assets.

### SSI - effective January 1, 2010

	INCOME BENEFIT RATE	ASSETS
SINGLE	\$674/month	\$2,000
COUPLE	\$1,011/month	\$3,000

To apply for SSI, contact the Social Security Administration.

### MEDICARE SAVINGS PROGRAM

Under the Medicare Savings Program (MSP) Medicare beneficiaries with low incomes and limited resources may be eligible to receive help in paying their Medicare costs. There are three categories of help available: QMB, SLMB, and QI.

### **QMB - Qualified Medicare Beneficiary**

- For individuals at 100% Federal Poverty Level (FPL).
- Helps pay for Part A and Part B premiums, deductibles, and co-insurance.

### **Specified Low-Income Medicare Beneficiary - SLMB**

- Pays for Medicare Part B Premium only.
- For individuals at 120% Federal Poverty Level (FPL).
- Must not be eligible for Medicaid.

### Qualified Individual - QI

- Pays for Medicare Part B Premium only.
- For individuals at 135% Federal Poverty Level (FPL).
- Must be recertified by Congress every one to two years and funding caps in place for the QI program.
- Must not be eligible for Medicaid.

### To Apply for QMB, SLMB, or QI

If you feel that you may qualify for QMB, SLMB or QI contact your local Department of Family Resources. Contact Social Security Administration if you do not already have Medicare Part A.

Normally when you qualify for a Medicare Savings Program, benefits will begin the month after the month in which approval occurred.

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### **MEDICARE SAVINGS PROGRAM January 1, 2010**

		INCOME	ASSETS
<b>QMB</b> Qualified	SINGLE	\$903	\$6,600
Medicare Beneficiary	COUPLES	\$1,214	\$9,910
<b>SLMB</b> Specified Low	SINGLE	\$1,083	\$6,600
Income Medicare Beneficiary	COUPLES	\$1,457	\$9,910
QI	SINGLE	\$1,219	\$6,600
Qualified Individual	COUPLES	\$1,640	\$9,910

- Figures for Medicare Savings Program change every Spring.
- \$20.00 income disregard is not included.
- There is no "spend-down" for Medicare Savings Program.
- You can have QMB/SLMB <u>AND</u> Full Medicaid. QMB/SLMB will pay every month.

### Losing Eligibility for Medicaid/QMB/SLMB

The Cost-of-Living Adjustment (**COLA**) with Social Security (SS) retirement benefits occurs in January and increases your SS income; however, new income levels for Medicaid/QMB/SLMB are effective in April. So, an increase in your SS income due to COLA may result in your getting a letter stating that you are no longer eligible for Medicaid/QMB/SLMB/QI. If you get a letter, contact your local Medicaid office for an explanation.

### MEDIGAP SUSPENSION WITH MEDICAID

You may ask your insurance company to suspend Medigap premiums (benefits will therefore be suspended also) for a period of up to 24 months (if your Medigap policy was purchased after 11/91). This suspension will not result in a cancellation.

### **Suspension Requests**

- You must make the request for a policy suspension to the insurance company that issued your Medigap policy within 90 days of your becoming eligible for Medicaid
- The suspension may last up to 24 months if the policy was purchased after 11/1991.
- During the suspension period the Medigap insurance company may not charge the policyholder for premiums and does not provide benefits.
- If Medicaid eligibility stops, the Medigap insurance company
  must reinstate the Medigap policy effective as of the date of
  losing Medicaid eligibility. You must notify the insurance
  company of the loss of Medicaid eligibility within 90 days of the
  loss.
- Medicaid may encourage you to keep your Medigap policy in force, allowing you to count the amount of the monthly premium towards your monthly spend-down for Medicaid eligibility.
- In some cases, Medicaid may pay your Medigap premiums.

It is possible for an individual to be receiving Medicare benefits, have a Medigap policy, and **also be receiving Medicaid**. In this instance, Medicare pays first, the Medigap policy pays second, and Medicaid pays third.

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### ALTERNATIVES TO NURSING HOME CARE

### **OPTIONS - Your Long Term Care Solution**

Indiana has waivers from the federal government which allows Medicaid in Indiana to offer alternatives to nursing home care. These alternatives are **In-home Services and Community-type Care.** In the past, it was easier to be approved for Medicaid funding for nursing home care. Now through the Indiana Family and Social Services Administration (FSSA) Division of Aging, the OPTIONS program has been developed to promote a full range of long-term care options.

The idea behind OPTIONS is to have the funds follow the individual, allowing them to choose their own care. These options include Assisted Living, Adult Day Care, and Adult Foster Care.

### **Assisted Living**

Assisted Living is a comprehensive, residential service provided through the Aged and Disabled Medicaid Waiver and the Assisted Living Medicaid Waiver. If you receive this service, you will reside in **an independent setting** provided by a licensed provider. Services include:

- Personal Care
- Homemaker Services
- Attendant Care
- Medication Oversight
- Social and Recreational programming

### **Adult Day Services**

Adult Day Services is a comprehensive **non-residential service** provided through the Aged and Disabled Medicaid Waiver. Under this waiver, you will receive services in a community setting at a **minimum of 3 hours a day, and maximum of 12 hours per day**. This service will allow you to live with family and allow your caregiver to maintain routine activities and responsibilities. Services include:

- Health, social, recreational and therapeutic activities
- Supervision
- Support Services
- Meals and/or snacks

### **Adult Foster Care**

Adult Foster Care is a comprehensive, residential service provided through the Aged and Disabled Medicaid Waiver. If you receive services through this service, you will reside in home with an unrelated primary caregiver and family. There may be up to two other consumers living at the residence as well. Services include:

- Personal Care
- Homemaker Service
- Attendant Care
- Companionship
- Medication Oversight
- Transportation
- Meals

### **Eligibility for OPTIONS**

You must be participating in the Medicaid Waiver, and these services must be on an approved Individual Plan of Care. Eligibility depends on meeting the following requirements:

- · Eighteen years of age or older;
- Meet financial guidelines for Medicaid;
- · Nursing Facility level of care; and
- Have a Level of Service rating of 1, 2 or 3. If the Level of Service rating is above a 3, then the level of care needed is too high for the services provided.

The Area Agencies on Aging (AAA) administer the waiver programs in addition to providing other community and in-home services. AAAs are responsible for individual assessments to determine medical needs. A case manager will be assigned to you. The case manager will complete an assessment to determine your edibility as well as your Level of Service rating. Case managers will work with you, your family, physician, and other health works to make sure your are receiving the services that meet your needs.

For more information:

- www.LTCOPTIONS.in.gov
- Area Agency on Aging 1-800-986-3505
- FSSA Division of Aging 1-800-545-7763

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### Other Programs Administered by Area Agencies on Aging:

- Family Support Services
- Social Service Block Grant
- Other local and privately supported services

### **Indiana Township Trustees:**

- There are 1,008 Townships in Indiana.
   Call 1-888-482-4639 for locations or visit their website:
   www.indianatownshipassoc.org
- Indiana law requires that the Township Trustees provide essential services to the residents to quickly meet the needs of an individual in an emergency.
- Poor relief health care assistance, utilities, housing, blood, and burial assistance when no other means of payment are available.

### **Community Health Centers**

 Community Health Centers provide medical services to people on a sliding fee scale. Community Health Centers can waive the Part B deductible. For a complete listing of these centers in Indiana, refer to section P-33 thru P-40.

### Counselor's Note: It can get Complicated!!

When you are assisting a client who is considering applying for Medicaid services: **Get the facts**.

Ask your client about what health-care and/or insurance coverage they currently have, or for which they may be eligible. (For example: Medicare, Medigap, group health, retirement health plans, military (VA) benefits, retired Railroad, Federal, and teachers plans)

Remind them to have copies of payments for incurred medical bills, receipts for prescription drug purchases, income statements, and statements of incurred medical bills for which they are making payments. All of these materials are needed by the Medicaid office in order to determine Medicaid eligibility.

### **HIP - Healthy Indiana Plan**

The Healthy Indiana Plan (HIP) is for uninsured Hoosier adults between 19-64. Parents or caretaker relatives of children in the Hoosier Healthwise program are likely candidates for HIP.

### Eligibility Requirements:

- You must earn less than 200% of the federal poverty level (FPL) for your household size.
  - A single adult earning no more than \$21,660 a year, or families of four earning approximately \$44,000 likely meet the basic financial requirements.
- You cannot be eligible for Medicaid, or Medicare.
- You must not have access to employer health insurance coverage whether or not it you have chosen to use this coverage.
- You must be uninsured for the previous 6 months.

### If you qualify for HIP, you will receive:

- A basic health benefit package once your annual medical costs exceed &1,100.
- A POWER Account valued at \$1,100 to pay for initial medical costs.
  - Contributions to the POWER Account are made by the State and you (based on a sliding scale). You will not pay more than 5% of your gross family income into the POWER Account—most pay less.
  - Any remaining funds in the POWER Account, may be rolled over to the next year providing the plan has determined you have completed all aged and gender appropriate your preventive services.
- Coverage for preventive services up to \$500 a year at no cost to you.
  - After the \$500 is met, preventative services are covered, but the POWER Account must be used if necessary.
  - Preventive services include: annual exams, smoking cessation, and mammograms.
- · Co-pays are required for all emergency services only.
  - However, the co-pay will be returned to you if the service was deemed a true emergency.

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### **Covered Services include:**

- Physician Services
- Prescriptions subject to a formulary (list of approved drugs)
- Diagnostic Exams
- Home Health Services
- Outpatient Hospital
- Inpatient Hospital
- Hospice
- Preventive Services
- Family Planning
- Case and Disease Management
- · Mental Health Services, including substance abuse treatment

You can access the HIP application online at:

www.in.gov/fssa/hip

Applications are also available at your local Department of Family Resources and Area Agency on Aging.

You can also call **1-877-GET-HIP-9** (**1-877-438-4479**) and request an application mailed to you.

Applications should be mailed to the following address:

FSSA Document Center PO Box 1630 Marion, IN 46952